SYMPOSIUM ON THE EDUCATION OF TOMORROW'S PHYSICIANS*

Afternoon Discussion

Graduate Medical Education

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DR. EDWARD FISCHEL. I wonder if members of the panel have any questions to ask each other. I should like to know what Dr. Kinney feels about the role of subspecialty boards in the future because this is in contrast, I think, to what the Association of American Medical Colleges (AAMC) feels should be the controlling force in the composition of the training programs.

DR. THOMAS KINNEY. I cannot speak officially for the AAMC but, to my knowledge, this organization does not have any quarrel with the specialty boards. I believe that if an entire academic medical center is to be accredited and given the responsibility for graduate training programs, then the specialty boards must be involved in setting up the standards for accreditation. The specialty boards should be regarded as quasi-public agencies similar to the examining board for state licensure. Their role should be to make certain that any individual who passes such an examination has demonstrated reasonable competence to practice his or her chosen specialty. It is important to remember that traditionally the specialty boards are concerned with the certification of an individual, while the AAMC is primarily interested in the accreditation of educational programs. There should not be any conflict between these objectives. The problem for the universities is

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that they are faced not only with 23 different specialty boards—all visiting at different times—to review their individual programs, but also with many other kinds of accrediting agencies, boards, liaison committees, and federal and state subdivisions—all pursuing their viewpoints and making it extremely difficult to develop coordinated educational programs. This causes confusion and considerable loss of time and money, and it discourages innovation. Further, I believe it is not possible to judge fairly separate segments of educational programs such as undergraduate and graduate education. For example, when a medical school is visited for accreditation in order to judge the quality of its educational program, a close look should be taken at the teaching hospital. Otherwise a major component in the education of the medical student is missed. To put a medical student in a hospital with poor graduate training programs and poor house officers is to deprive the student of a sound and well-rounded medical education. Therefore I believe that we should be aiming for institutional accreditation. If this comes about, the interest of the specialty boards should be represented on the site-visiting team.

DR. FISCHEL. Any other questions from the panel members? If not, I invite questions from the audience.

DR. SOLOMON G. HERSHEY *(Albert Einstein College of Medicine, Bronx, N. Y.)*. This is a simple question for Dr. Rousselot. Professionally, some of us think we understand the difference between a primary physician and a family physician. But as to public agencies such as the Bureau of Health Manpower Education (BHME)—the guidelines they use, such as those for the Area Health Education Committee (AHEC) program—is there a difference, and if so, what is it?

DR. ROUSSELOT. In terms of the guidelines mediated by the National Institutes of Health (NIH), we consider the designation primary physician as a generic term. Thus the broader definition of a primary physician might be anyone from an internist to a pediatrician to a psychiatrist or even a surgeon. However, the Bureau of Health Manpower Education within NIH, during fiscal year 1972, is supporting 650 residents in 52 approved Family Practice Residencies.

DR. HUGO SMITH *(Temple University School of Medicine, Philadelphia, Pa.)*. Dr. Southworth, I wonder if it is fair to judge the quality of a training program only by looking at the candidate when he comes off the end of a production line. It seems to me it would be

very unfair to certain programs if one looked only at the end product.

DR. SOUTHWORTH. I could not agree more fully, but we do not yet have the means of doing what you say. I think that perhaps the in-service examination when pushed a little further will do this, because if, for instance, a house officer in his first year of hospital work, whether it is an internship, or a residency, or whatever, is rated and then re-rated two years later, you can see what is accomplished. But it is better to know just how good the end product is.

DR. FISCHEL. Any other questions?

DR. MILTON LOWENTHAL *(New York Medical College, New York, N. Y.)*. I should like to direct a question at the general title of the meeting rather than to the panel, as a patient of 21 years with a chronic illness. The management of my illness helped sharpen some concepts that I have harbored for a long time and were recently well expressed by Lennart Levi in *Acta Medica Scandinavica.** Levi said, and I paraphrase, that my physician's problem is how to evaluate the interaction of psychosocial stresses and my psychobiological problem. Clinical care is more art than science. The question for medical educators is: How are we going to get a future physician who is able to bring more science to clinical care? Incidentally, I want to make sure I am not misunderstood: this is not a humanistic question. It is a very powerful scientific question: How can my physician identify my biological uniqueness in terms of my illness and properly evaluate my responses to therapeutic intervention?

DR. FISCHEL. I think you have a broad question here which is more than a bit rhetorical and certainly concerns us all. I do not think any of us could pose a cogent answer to it. Dr. Thomas is going to address himself to it, I hope.

DR. LEWIS THOMAS. I have a question for Dr. Rousselot. I am a little scared by his description of the new medical school experiment involving Wilkes College and Hahnemann. I suspect that the proposed experiment is going to sound attractive, especially to legislators, because it is not going to cost as much money as many schools are costing today. Moreover, I am not sure it is going to be as good as it looks. I wonder whether Dr. Rousselot could tell us what plans exist for the evaluation of that program and, more important, are there any

*Levi, L.: Stress and distress in response to psychosocial stimuli. *Acta Med. Scand.* (Suppl. 528), 9-166, 1972.

other experiments of this nature on anyone else's drawing board at the present time?

DR. ROUSSELOT. I shall answer your second question first. There is another interesting experiment—the Washington, Alaska, Montana, and Idaho (WAMI) project—which involves a consortium of four universities oriented around the University of Washington, including the University of Alaska, the University of Montana, and the University of Idaho. In this program the students will receive their basic science education at their home universities but their clinical science at the University of Washington. Each is to receive his degree from his parent university, as I understand it. On the question of evaluation, all our programs are subject to evaluation almost from their inception. This means obviously that within a 12-month span there is little or no quantifying of the problem. This Hahnemann-Wilkes experiment will be evaluated very carefully. There are certain other facets of it which I can not describe because of time limitations: for example, a rather elaborate audiovisual communication between Philadelphia and Wilkes over television.

The ultimate outcome of this experiment I hesitate to predict. I mentioned that five community hospitals are involved in Wilkes-Barre, and it is obvious that five community hospitals in any community are going to vary considerably in their teaching potentials and in their products.

DR. WILLIAM E. CADBURY. I know of two other programs that are somewhat similar, although I do not know whether they are in effect yet. Is it not true that Lincoln and Hahnemann are considering a similar program?

DR. ROUSSELOT. There are many such plans under consideration. I mentioned only those that have been passed by the Advisory Council and have been funded.

DR. CADBURY. Quite independently of anything federal, Northwestern University is attempting to get funds for a program which they call, I believe, the Urban Doctors Program, wherein they are taking innercity students from Chicago and encouraging them to spend two years at the YMCA Community College. I believe the intention is for the students then to transfer to Northwestern Medical School for their last four years to get the M.D. degree. I do not think that the sponsors of the program have obtained funding for it yet, but they are seeking it actively.

DR. FISCHEL. Dr. Jarcho.

DR. SAUL JARCHO. What I have is not a question, but a word of sympathy for deans, professors, and administrators who are engaged in what is now called evaluation. In a French medical school in the last century the student who graduated next to last, 29th I think, in a class of 30, was Claude Bernard.

DR. FISCHEL. Dr. Berger.

DR. HERBERT BERGER (*New York Medical College, New York, N. Y.*) I think Dr. Thomas may have preempted my question to you, Dr. Rousselot, but it would seem from our past experience that two factors might obtain. One of these is that the graduation of 2,000 more medical students and young physicians at enormous expense—I am sure you know the figures and I do not—will not put a single doctor in those 132 counties that you are worried about or into the thousands of municipalities that do not have physicians. Further, I believe from past experience that taking individuals from the community in northeastern Pennsylvania and educating them in the hope that they will return to that community is, I am afraid, a specious hope. Certainly, I have learned that this has not been the experience in Brooklyn, where very few graduates return to practice there. This has been true throughout ghetto and rural areas; consequently one wonders how it will be possible to attract graduates to unattractive areas where they may not wish to practice.

DR. FISCHEL. Dr. Rousselot, do you want to discuss that issue?

DR. ROUSSELOT. I am inclined to agree with you, Dr. Berger, with respect to this question of recruiting individuals from an area, be it urban or rural, in the hope that they will return to it to practice. I have much more confidence in the AHEC concept of attempting to redistribute all types of health professions. A speaker earlier in this symposium mentioned the idea of developing medical centers, if you will, in underserved areas. This would be conceivably much more attractive professionally as well as economically to the health professional.

DR. STEVEN JONAS. As we have been hearing throughout this symposium, and as those of us who are in medical education know, the curricula in certain schools are being reduced from four to three years. In many schools where there are still four-year curricula, there are increasing amounts of elective time, and smaller and smaller amounts of general clinical time.

The internship is gradually being eliminated. One of the results of

all these processes is that all physicians emerging now are going to have less and less time to gather the kind of general clinical skills that a physician needs—that I think any specialist or generalist needs—in approaching patients as people. The second problem that arises from these trends, it seems to me, is that of pushing back earlier and earlier in the student's life the point in time when he must make a decision on specialization, even if he chooses the specialty of family practice. That creates the problem of setting the point in time for decision making at a less mature stage. It also creates difficulties if one wants to change specialties at some point in one's training. So I should like to hear from any of the panelists what they think specifically about 1) the shortening of the amount of time devoted to the development of general, clinical, patient-oriented skills and 2) the problem of the time to choose a specialty.

DR. FISCHEL. Dr. Kinney, will you comment?

DR. KINNEY. Let me take the second part of the question, and perhaps my colleagues who are clinicians will take the first part. At Duke University we believe that students are capable of making early decisions on careers. This has not been a problem for our students. By the end of the second year medical students are 23 or 24 years old and should be able to make this decision. They are adults. Further, I am not concerned if an early decision turns out to be wrong. There will still be time to change, for the student is not committed too deeply, and it is not too late to try something else. For example, I cannot see that it harms a student to start in internal medicine and then decide upon ophthalmology, for I suspect he will be a better opthalmologist because of it.

DR. FISCHEL. Dr. Ragan, do you want to comment on that?

DR. RAGAN. Anecdotally, the house staff of the Harlem Hospital Center was composed of a lot of activists, and I was shocked to find a reasonable number of them taking a year off during their house-staff training program. Whether this was because they had made their decisions too soon or whether it was just a manifestation of activism I do not know. But this never happened in my day. As far as your first question goes, I think we are all frightened to death.

DR. SOUTHWORTH. I should like to come to the defense of the medical student who, I think, is a good deal more mature nowadays when he has finished his two years of medical school than he was 10 and

perhaps even five years ago. I may be wrong, since I am not a dean, but it is my feeling that when students are given a lot of elective time there are a few who rush for something they are particularly interested in, but the great majority settle down to take things that really do give them a broad experience. It is interesting to note how many fall back into the old type of curriculum. They do now get an opportunity, and they do have a desire to strike out into new parts of the world and to do things that take them back to primary physician's work. This is probably a healthy trend, but I should like to know how much of the elective time really goes into clinical experience.

DR. JESSE MAHONEY (*New York University, New York, N. Y.*). Dr. Rousselot: Does the anticipated increase in medical schools include an armed force services school?

DR. ROUSSELOT. As some of you may or may not know, the president recently signed into law so-called HR2, now P.L. 92-426, which is to establish a medical school under the auspices of the Department of Defense. This particular law has two parts to it. One is the establishment of the medical school, and the second is the establishment of 5,000 scholarships in all the health professions: medicine, dentistry, nursing, and the allied health professions.

DR. VILTER. It is important for the universities to assume responsibility for graduate education, but I wonder if any consideration has been given to the question of who will assume the cost of evaluating this graduate education. Obviously we are taking the cost now out of the money for education. For instance, to evaluate a residency program in internal medicine satisfactorily, I am going to have to put on one additional secretary just for the evaluation process.

If this applies to 28 subspecialties, the costs of evaluation are going to increase greatly. Has there been any thought about where this money is going to come from? It is not in anybody's budget right now. The second question is: Does the panel feel that a psychiatrist, for instance, ought to have an internship before he goes in depth into psychiatry? What about an obstetrician and gynecologist or an ophthalmologist? Should these specialists have general training which they are not getting in the fourth year of medical school? And the third question is: How will the clinical program at Wilkes-Barre be evaluated and by whom? How will the end results of this program be ascertained, particularly at the clinical competence level?

DR. FISCHEL. We seem to have questions for three of our panelists. Dr. Southworth: What about the cost of evaluating procedures?

DR. SOUTHWORTH. Evaluating procedures until now have been done in two ways (through the American Board of Internal Medicine). First, there has been a study that attempted to see how good the examination techniques of the board were in determining the increases in knowledge and skills that house officers acquired during their training. This also helped to show how well each training program gave additional knowledge and sophistication to candidates. This study was an expense of the board and was paid for by the candidates through their fees. It was a legitimate expense in that it helped to gauge the qualifying procedure. The second type, the in-service evaluation and the secretarial work that goes with it, I think, will be up to the professor or the program director. If he wants this evaluation he will have to pay for it.

DR. ROUSSELOT. Dr. Fischel: may I answer partially another part of that question—the question of who is going to assume the cost? This is all important because, as computed for 1971, direct costs for residency stipends alone in the United States approximated $308 million.

I do not think many of us realize the amounts involved. The question of deciding which part of a resident's program is education and research training and what part is service is a moot one. Dr. Kinney mentioned three of the major elements that contribute to payment now. We might also add the traineeships and fellowships that many institutions use to help defray the cost of their residents, whether they are from foundations, from American Cancer, or from research programs.

In other words, there are many facets to this question. Our bureau has been charged under legislation to address itself to that subject, and we now have to analyze critically, by past analysis and actual audit, residents' programs in many university centers and nonuniversity centers, in an attempt to come to grips with the actual costs of education versus service.

You may or may not know that the Institute of Medicine at the National Research Council is making the same analyses for undergraduate medical education.

DR. FISCHEL. I do not know whether we shall get answers to the other two parts of your question, Dr. Vilter, but let me ask Dr. Ragan if he has some opinions on the value of an internship as a general base before going into psychiatry, obstetrics, and other fields.

DR. RAGAN. Much depends on the individual school. Some students are entirely capable of graduating after three years, but in general most want an exposure to the medical wards before they go into their first postgraduate year. I mentioned that this has been attempted and has been difficult to accomplish because of the nonavailability of teaching patients who are fully used by the present programs.

DR. FISCHEL. We have time for one more question. Dr. Eichna.

DR. LUDWIG W. EICHNA. I had hoped that this panel would consider the fact that postgraduate education is not an internship or residency or a fellowship but that the education goes on for a lifetime. Accordingly, Dr. Rousselot, I think that a statement that $450 million went to the education of the house officer does not take into consideration how much of the $450 million went into the education of the physician by the house officer.

DR. FISCHEL. Dr. Deitrick.

DR. JOHN E. DEITRICK. I have a tremendous itch to ask some questions myself, but I shall not, except to make one remark about the costs, which came up in this discussion, of the medical education and training of residents. I saw a report recently on a study done in Hartford, Conn., where an attempt was made to substitute paid physicians for house staff. The costs came out almost exactly the same. If that can be repeated, we may have a bargain in the house staff. Nobody has said how much it would cost to provide 24-hour care to patients seven days a week by men whose average salary is $35,000 a year. A house staff with a maximum salary of $20,000 is still, I think, an excellent investment from the standpoint of the public.